Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1802-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted at http://www.regulations.gov

May 20, 2024

Re: CMS, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025," CMS-1802-P (Apr. 3, 2024), https://www.govinfo.gov/content/pkg/FR-2024-04-03/pdf/2024-06812.pdf

Dear CMS Colleagues:

The Center for Medicare Advocacy (Center) submits comments on the proposed rule to update Part A payments to skilled nursing facilities in the traditional Medicare program and to revise the civil money penalty program for skilled nursing facilities and nursing facilities.

The Center for Medicare Advocacy is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance to people nationwide, primarily the elderly and people with disabilities, to help them obtain necessary health care, therapy, and Medicare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care and provides training regarding Medicare and health care rights throughout the country. It advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage. These comments are based on the Center's experiences talking with and representing Medicare beneficiaries and their families and advocates.

The Long Term Care Community Coalition (LTCCC) is a nonprofit organization dedicated to improving quality of care, quality of life and dignity for elderly and disabled people in nursing homes, assisted living and other residential settings. LTCCC focuses on systemic advocacy, researching relevant national and state policies, laws and regulations in order to identify relevant issues and develop meaningful recommendations to improve quality, efficiency and accountability. In addition to providing a foundation for advocacy, LTCCC uses this research and the resulting recommendations to educate policymakers, consumers and the general public. Consumer, family and LTC Ombudsman empowerment are fundamental to our mission.

Overview of Primary Concerns

The proposed revisions to the civil money penalty (CMP) program, while positive in and of themselves, could have the effect of making the enforcement system even more complex and less effective than it is now and thus could have the unintended consequence of reducing facility accountability for poor care.

In addition, the Center and LTCCC are concerned this year, as we were last year, about what is missing in the proposed rules: any discussion of, or efforts to address, the dramatic decline in therapy services for nursing home residents following implementation of the Patient-Driven Payment Model (PDPM). We are particularly concerned about CMS's failure to ensure meaningful realization of maintenance coverage of nursing and therapy services in SNFs, as mandated in 2013 by the federal district court in Vermont in the nationwide class action *Jimmo v. Sebelius*.

Detailed Comments about Primary Concerns

New rules for civil money penalties (CMPs)

Before discussing the proposed rule, the Center and LTCCC address how and why we got to the CMP rules we have today.

The Institute of Medicine's (IoM) 1986 report, *Improving the Quality of Care in Nursing Homes*, which is often described as the legislative history of the 1987 Nursing Home Reform Law, identified the problems of enforcement of standards of care that existed in the 1980s. In Chapter 5, "Enforcing Compliance with Federal Standards," IoM described inadequate enforcement as a national problem:

> Although public attention is focused on the relatively few scandalous cases, a more serious issue appears to be the large numbers of marginal or substandard nursing homes that are chronically out of compliance when surveyed, may or may not be subject to mild sanctions, temporarily correct their deficiencies under a plan of correction, and then quickly lapse into noncompliance until the next annual survey. (p. 146)

IoM described four categories of problems with enforcement:

> (1) federal and state orientation and attitudes toward enforcement; (2) the federal rules and procedures; (3) state variations in enforcement authority, policies, and procedures; and (4) inadequate federal and state resources committed to enforcement. (p. 147)

IoM identified features that are necessary for a fining system to be effective:

> For a fining system to be effective, it is essential that the administrative and legal delays be avoided by prompt, short hearings, that the fines be graduated according to seriousness, duration, and repetition of the violations, and that fines be used to deter further violations. All fines should be large enough to be more costly than the money saved by the

> violations. Fining systems should be versatile enough to allow correction of long-serious violations, but immediately punish life-threatening violations. (p. 166)

The Federal Nursing Home Reform Law established a comprehensive enforcement system, identifying jeopardy and non-jeopardy enforcement options, identifying a range of remedies (denial of payment, civil money penalties, temporary management, termination), requiring specified remedies for uncorrected deficiencies and repeated noncompliance, inclusion of a construction paragraph (not limiting other remedies, including remedies available at common law to individuals) and more. 42 U.S.C. §§1395i-3(h), 1396r(h), Medicare and Medicaid, respectively. The Reform Law explicitly authorized civil money penalties (CMPs) of up to $10,000 for each day of noncompliance. 42 U.S.C. §§1395i-3(h)(2)(B)(ii)(I), 1396r(h)(2)(A)(ii), 1396r(h)(3)(C)(ii)(I).

Final enforcement rules were published in 1994, 59 Fed. Reg. 56116 (Nov. 10, 1994). The final rules discuss CMPs at length and create two ranges, $50-$3000 per day for non-immediate jeopardy deficiencies and $3050-$10,000 per day for jeopardy deficiencies. CMS writes:

> We set the amounts of the penalties within the two ranges to allow consideration of the unique characteristics of each situation of noncompliance. It is inappropriate to refer to a "consistent" application of civil money penalties because each situation of noncompliance and the factors that affect the amount of the civil money penalty are unique for each facility.

59 Fed. Reg., 56203.

The rule addressed a commenter's concern that "there is no provision in the regulation which would prohibit daily penalties from mounting." 59 Fed. Reg., 56203. The response was:

> Response: A facility can always stop the accrual of a civil money penalty by correcting the situation that caused the noncompliance. With regard to all remedies, we received many comments recommending that the standard of substantial compliance with sections 1819(b), (c), and (d) and 1919(b), (c), and (d) of the Act be incorporated into the rule as an acceptable measure of compliance. As discussed previously in this preamble, we accept this comment and we will lift remedies imposed for noncompliance when a facility is in substantial compliance with sections 1819(b), (c), and (d) and 1919(b), (c), and (d) of the Act. 59 Fed. Reg., 56203.

A July 1998 report by the Government Accountability Office (GAO) found that, nationwide, in 99% of cases where penalties were proposed, final CMPs were not imposed because facilities corrected the deficiencies. GAO, California Nursing Homes: Care Problems Persist Despite Federal and State Oversight, GAO/HEHS-98-202 (Jul. 1998).

The GAO found:

> Between July 1995 and May 1998, California's DHS gave about 98 percent of noncompliant homes a grace period to correct deficiencies. For nearly the same period (July 1995 to April 1998), the rate of noncompliant homes receiving a grace period

> nationwide was 99 percent, indicating that the practice of granting a grace period to nearly all noncompliant homes is common across all states.

p. 26.

The GAO also wrote:

> We also found that surveyors can miss problems that affect the safety and health of nursing home residents and that even when such problems are identified, enforcement actions do not ensure that they are corrected and do not recur. (p. 3)
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> Moreover, we believe that the extent of current serious care problems portrayed in these federal and state data is likely to be understated. We found that homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations. In addition, we found instances of irregularities in the homes' documentation of the care provided to their residents, such as missing pages of clinical notes needed to explain a resident's injury later identified through physician observation. These types of irregularities could shield from surveyor scrutiny such problems as inadequate staffing or avoidable injuries. Finally, in visiting homes selected by California DHS officials themselves, our team found multiple cases in which DHS surveyors did not identify certain serious care problems—including unaddressed dramatic weight loss and related nutritional problems. Surveyors missed these and other care problems, in part, because federal guidance on conducting surveys does not include sampling methods that can enhance the spotting of potential problems and help establish their prevalence. (p. 4)
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> Even when the state identifies serious deficiencies, HCFA's enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected. (p. 4)

In essence, CMS (then, the Health Care Financing Administration, HCFA) had reinstated the enforcement system that IoM had said in 1986 needed to be corrected.

In 1999, HCFA published interim final rules creating a per instance civil money penalty process. 64 Fed. Reg. 13354-13360 (Mar. 18, 1999). Although not directly citing the GAO's 1998 report, HCFA explained that

> it has largely been the case that, except where immediate jeopardy has been involved or the provider has been found to be a poor performing facility, civil money penalties have not been imposed where facilities have been able to correct deficiencies before a predetermined date for the completion of corrections.

64 Fed. Reg., 13355. Although facilities avoided per day CMPs by correcting deficiencies before the effective date of the proposed per day CMPs, "subsequent to achieving compliance these same facilities have failed to maintain substantial compliance" – they were "yo-yo" facilities. 64 Fed. Reg. 13356. In contrast to per day CMPs, the new per instance CMP could be imposed for the

existence of a deficiency, without giving facilities a prior opportunity to correct the deficiency and avoid the CMP.

HCFA made two policy decisions that limited the effectiveness of per instance CMPs, however. First, it said that only one type of CMP could be imposed following a survey – either a per day CMP or a per instance CMP – but not both at the same time. 64 Fed. Reg., 13356. Second, it limited per instance CMPs to $10,000 (since increased for inflation). *Id.*

Despite the fact that per instance CMPs would generally result in lower total CMPs (as actually happened), the American Health Care Association filed a case in federal court challenging the legality of the per instance CMP rule. *American Health Care Association v. Shalala*, No. 99-1207 (GK) (D.D.C. 1999). The court dismissed the case and denied AHCA's motion for summary judgment on March 6, 2020.

The two prior Administrations issued guidance on CMPs.

The Obama Administration made per day CMPs the default type of CMP in 2014. CMS, "Civil Money Penalty (CMP) Analytic Tool and Submission of CMP Tool Cases," S&C: 15-16-NH (Dec. 19, 2014) (Analytic Tool, p. 21).

The Trump Administration explicitly replaced S&C:15-16-NH and revised the CMP Analytic Tool on July 7, 2017, making per instance CMPs the default type of CMP. CMS, "Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool," S&C: 17-37-NH (Jul. 7, 2017).

What does this history of CMPs tell us? The CMP remedy can be one of the most effective enforcement tools available because it can be assessed according to the seriousness of a facility's noncompliance and the length of time that the facility has remained out of compliance – that is, it can reflect the scope and severity of the facility's noncompliance. The history also tells us that CMS has not used the CMP remedy effectively to make noncompliance more costly than compliance, as the IoM Committee identified as both necessary and appropriate.

In the proposed rule, CMS proposes two substantial changes to the CMP rule:

1. permitting both per instance and per day CMPs to be imposed for the same survey
2. extending from one to three years the time period in which a CMP may be imposed for past noncompliance

The Center for Medicare Advocacy and LTCCC support both policy changes.

As CMS correctly observes, there is no statutory prohibition against imposing both types of CMPs for a single survey. Using both types of CMPs at the same time would add new options and new flexibility for survey agencies and strengthen enforcement.

The Reform Law authorizes CMPs for past noncompliance. 42 U.S.C. §§1395i-3(h)(2), 1396r(h)(1), (3). The current regulation describes CMPs as available for "past noncompliance since the last standard survey." 42 C.F.R. §488.430(b). CMS's proposed revision of §488.430(b)

says that CMPs may be imposed for past noncompliance "since the last three standard surveys." This change is also fully supported by the language of the law and would also strengthen enforcement options.

However, the Center and LTCCC are concerned that CMS is encouraging states and CMS to start per day CMPs on the first day of the survey, not on the identifiable date that preceded the survey, as authorized by 42 C.F.R. §488.440(a)(1). The Center is also concerned that requiring CMS to provide the reason(s) for each of the various CMPs will unnecessarily complicate the enforcement system and make states and CMS less likely to impose both multiple per instance CMPs and a per day CMP for the same survey.

With respect to starting CMPs on the first day of the survey, we refer to the preamble, where CMS describes the current CMP process as creating "a perception of inequity in the total amount calculated for a CMP." 89 Fed. Reg., 23479. CMS uses the word "consistent" or a variation four times on pages 23478-23480. CMS is plainly focused on the amount of per day CMPs, since per instance CMPs, by definition, are limited in total amount. CMS's concern reflects sympathy with nursing homes' complaints about CMPs, not with historical criticism of the ineffectiveness of implementation of the nursing home enforcement system (discussed in decades of GAO reports[1]).

There are two reasons that per day CMPs can be large – first, because per day CMPs can start to accrue before the survey begins, if surveyors can determine that noncompliance began earlier than the survey, as authorized by 42 C.F.R. §488.440(a)(1); and second, because per day CMPs continue to accrue until surveyors determine (usually after a revisit) whether the facility has corrected its

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[1] See, for example, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*, GAO-19-433 (Jun. 13, 2019); *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280 (May 9, 2011); *Nursing Homes: Some Improvement Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear*, GAO-10-434R (May 27, 2010); *Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could Be Strengthened*, GAO-10-197 (Apr. 19, 2010); *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO-10-70 (Dec. 28, 2009); *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO-08-517 (May 15, 2008); *Nursing Homes: Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations*, GAO-07-373 (Jun. 29, 2007); *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241 (Apr. 23, 2007); *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117 (Jan. 17, 2006); *Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline,* GAO-03-1016T (Jul. 17, 2003); *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives,* HEHS-00-197 (Sep. 28, 2000); *Nursing Homes: HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality Care*, HEHS-00-27 (Nov. 4, 1999); *Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit*, GAO-09-689 (Sep. 28, 2009); *Nursing Homes: Proposal To Enhance Oversight of Poorly Performing Homes Has Merit*, HEHS-99-157 (Jun. 30, 1999); *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, HEHS-99-80 (Mar. 22, 1999); *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, HEHS-99-46 (Mar. 18, 1999); *Nursing Homes: Quality of Care More Related to Staffing than Spending*, GAO-02-431R (Jul. 15, 2002); *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, GAO-02-312 (Mar. 5, 2002), https://www.gao.gov/products/gao-02-312; *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, HEHS-98-202 (Jul. 27, 1998).

deficiencies, returned to substantial compliance, and showed that it will remain in compliance, ending the CMP (unless the facility can demonstrate that it returned earlier to substantial compliance). Since these concerns are not applicable to per instance CMPs, CMS's criticism is focused on per day CMPs and their presumed unfairness (to nursing homes).

CMS suggests that the per day CMPs could begin on the first day of the survey. We oppose this suggestion and urge CMS to confirm that whenever surveyors determine that noncompliance began earlier than the first day of the survey, the per day CMPs should begin on the date that surveyors determine that noncompliance first began. This presumption more effectively stresses and implements the obligation of facilities to be in compliance with Requirements of Participation, 24 hours per day, 365 days per year, not just during surveys.

The Center and LTCCC propose the following principles and guidance for CMPs.

1. Retain the proposed decision, and the proposed language at 42 C.F.R. §488.434(a)(2)(iii), authorizing CMS and state agencies to impose both a per day and a per instance CMP as a result of a single survey. Different types of facility noncompliance can make both types of CMPs appropriate. As CMS correctly observes, there is no prohibition in federal law to imposing both types of CMPs for the same survey. Using both at the same time would add new options for survey agencies and strengthen enforcement.

2. Retain the language proposed at 42 C.F.R. §488.430(b) that authorizes CMPs for past noncompliance that occurred since the last three standard surveys.

3. Reinstate the Obama guidance that per day CMPs are the default type of penalty.

4. Reiterate that, as authorized by the rule, 42 C.F.R. §488.440.(a)(1), per day CMPs should generally begin on the first day that surveyors identify and document noncompliance, even when that day is earlier than the first day of the survey.

The diminution of therapy services in SNFs

We repeat our concerns about the diminution of therapy services in SNFs.

In the final rule establishing PDPM, 83 Fed. Reg. 39162 (Aug. 8, 2018), CMS described the overpayments for therapy services under the prior reimbursement system, Resource Utilization Groups, 83 Fed. Reg. 39183-39185. CMS recounted commenters' concerns, with which it agreed, that PDPM could result in facilities' reducing therapy services that residents actually need, in light of the dramatically changed financial incentives in PDPM. *Id.* 39186. CMS added items to the discharge assessment to allow CMS to monitor the amount and intensity of therapy received under PDPM.

In the final rule published in 2018, CMS indicated that it would give facilities a "non-fatal warning edit" if they exceeded the permissible uses of group and concurrent therapy. *Id.* 39239. CMS also indicated that it would continue to monitor group and concurrent therapy utilization "and consider making future proposals to address abuses of this proposed policy or flag providers for additional

review should an individual provider consistently be found to exceed the proposed threshold after implementation of the proposed PDPM." *Id*. 39239.

In the final rule published August 7, 2019, just as PDPM was to go into effect, CMS revised the definition of group therapy to permit groups of two to six residents. It reported:

> Anecdotally, we have been told by an industry group that they would advise their facilities to give as much group and concurrent therapy as possible based on the limit we set for group and concurrent therapy, so that if the limit were 50 percent, they would advise their facilities to give 50 percent group and concurrent therapy. This group informed us that they plan to advise their facilities to furnish 25 percent of all therapy as group and concurrent therapy.

84 Fed. Reg. 38728, 38749 (Aug. 7, 2019). Despite this blatant industry statement that it would encourage facilities to exploit whatever therapy rules CMS permitted, CMS essentially ignored the statement and reiterated its longstanding policy that most therapy should be individual therapy:

> We note that we do not believe it would be appropriate to automatically provide the maximum amount of group and concurrent therapy permitted under the percent cap set by Medicare without considering the individual clinical needs of each patient. As we stated previously, we expect therapists to determine the frequency, duration, and modality of therapy based on sound clinical reasoning and the individual needs of each patient. Further, as we stated above and in the FY 2020 SNF PPS proposed rule (84 FR 17635), we continue to believe that individual therapy is the preferred mode of therapy provision and should be considered the standard of care in therapy services provided to SNF residents.

Id. 38749-38750. CMS also promised: "We plan to implement a robust monitoring program to assess compliance with the 25 percent cap, and based on our findings, we may propose taking additional action in future rulemaking." 84 Fed. Reg. 38728, 38748 (Aug. 7, 2019).

As PDPM went into effect in October 2019, the media immediately reported that thousands of therapists had been laid off.[2]

In the proposed annual update to Medicare Part A payment rates, published April 15, 2021, CMS presented "some of the results of our PDPM data monitoring efforts." 86 Fed. Reg. 19954, 19985 (Apr. 15, 2021). CMS reported a dramatic 30% decline in therapy services received by residents at SNFs, from 91 minutes per resident per day to 62 minutes per resident per day, and the substantial shift from individual therapy to group and concurrent therapy. *Id.* 19986. CMS noted that PDPM had resulted in significantly higher payments to SNFs in the first year of its implementation, $1.7 billion, or 5%. CMS's response was to consider recalibrating the Medicare rates, which the Center supported. The Center for Medicare Advocacy noted in our 2021 comments that CMS had immediately and fully recalibrated rates for Fiscal Year 2012 when the transition from RUG-III to RUG-IV resulted in $4.47 billion in overpayments, 12.5%, in Fiscal Year 2011.

[2] *See* Alex Kacik, "Therapists decry layoffs amid SNF reimbursement overhaul," *Modern Healthcare* (Oct. 2, 2019); Danielle Brown, "Therapist advocates sharing layoff concerns with CMS," *McKnight's Long-Term Care News* (Oct. 3, 2019).

In 2021, however, CMS chose in the final rules not to recalibrate the Medicare rates, in light of COVID-19 and the public health emergency. **CMS did not propose any efforts to ensure that residents received the therapy they were denied in the transition to PDPM.**

We repeat the recommendations that the Center made in June 2021 in response to the alarming decline in therapy services:

1. **CMS should analyze the resident Discharge Assessment data since implementation of PDPM and should publicly report its findings.**

2. **CMS should add a mandatory financial penalty for facilities that exceed the 25% cap on group or concurrent therapy, with the penalty set at an amount to exceed the cost of compliance with the limitations on group or concurrent therapy.**

3. **CMS should identify nursing facilities that dramatically changed the therapy services they provide following implementation of PDPM and direct state survey agencies to conduct surveys at those facilities in order to identify whether they violated the Requirements for Participation, including resident assessment and care planning, professional standards of quality, and provision of care and services. If survey agencies identify noncompliance, CMS should cite appropriate deficiencies and impose enforcement actions, specifically, per day civil money penalties that exceed the cost of compliance.**

4. **CMS should consider reinstating a requirement for multiple resident assessments (as in the prior reimbursement system, Resource Utilization Groups) to prevent the gaming (and overstatement) that occurs with the single assessment on the fifth day of a resident's stay, as now required by PDPM.**

In 2022, CMS proposed to recalibrate Medicare rates by 4.6% (less than the percentage identified by CMS), $1.7 billion, with a delayed and phased implementation of the recalibration. 87 Fed. Reg. 22720, 22737-22743 (Apr. 15, 2022).

We reiterate the Center's 2021 recommendations about therapy and the need for CMS to take strong action against facilities that deny residents appropriate therapy services. We urge CMS to take all appropriate actions to ensure that residents actually receive all the therapy services they need, whether for improvement or maintenance.

We also reiterate our 2018 concerns about PDPM's ignoring the Court-Ordered Settlement in *Jimmo*, which confirms coverage of maintenance therapy (and maintenance nursing) in SNFs. Although PDPM undermines all therapy services for SNF residents, we expressed concern that PDPM would be particularly devastating for maintenance therapy.

On January 24, 2013, Chief Judge Christina Reiss of the federal District Court in Vermont approved a nationwide Settlement, negotiated by a class of Medicare beneficiaries, who challenged Medicare's "improvement standard." The Settlement, ¶6.a, confirms that the Medicare law and regulations provide coverage of maintenance therapy services in SNFs (and also home health and

outpatient therapy) if such therapy is needed "to maintain the patient's current condition or to prevent or slow further deterioration . . . so long as the beneficiary requires skilled care for the safe and effective performance of the program." On February 16, 2017, the Court issued an additional order and approved a Corrective Statement that CMS was required to reproduce in full on the dedicated webpage that the Court also ordered CMS to establish. The Corrective Statement, which now appears on CMS's *Jimmo* homepage as an "Important Message about the Jimmo Settlement," says, in part, "The *Jimmo* Settlement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve."

To the extent that SNFs are required to change their practices to provide maintenance therapy to residents for whom it is medically necessary, the Medicare reimbursement system must reflect these therapy services. At the third Technical Expert Panel that advised CMS and reviewed Acumen's research on the new Medicare reimbursement system, which ultimately became PDPM, Acumen staff indicated that they would incorporate *Jimmo* only if they had hard data documenting which facilities properly implement the Settlement and how much such implementation costs. Since that task was impossible to meet, Acumen's position was that the requirements of *Jimmo* would not be included in the proposed system, but could be added at a later time, if and when the reimbursement system was further revised. Accordingly, the original NPRM for PDPM reflected Acumen's failure to incorporate *Jimmo.*

That problem continues to this day. *Jimmo* has now been the law of the land for more than a decade. CMS must ensure that *Jimmo's* mandate for maintenance coverage of nursing and therapy services in SNFs is fully implemented in the Medicare reimbursement system. To date, it has not done so.

Additional Comments

Hospital inpatient wage data, 89 Fed. Reg., 23431

As in past years, CMS proposes to continue using hospital inpatient wage data for SNFs. This policy automatically and artificially inflates SNFs' reimbursement rates because it is well-known, widely recognized, and publicly reported that nursing facilities typically pay lower salaries to their nursing staff than hospitals pay – 10-20% lower, according to Mary Ersek, "The Waltz: To Improve Nursing Home Care, Invest In The Workforce," *Health Affairs* (May 26, 2022).

Hospital wages for registered nurses and certified nurse aides are typically far higher than SNF wages, according to the Bureau of Labor Statistics (May 2023).

Category of nursing staff	Hospital salaries	Skilled nursing facility salaries
Registered nurse	$96,830	$82,930
Licensed practical nurse	$55,380	$63,730
Certified nurse aides	$40,840	$38,730

From: Bureau of Labor Statistics (May 2023)

RNs, https://www.bls.gov/oes/current/oes291141.htm (hospitals); SNFs through Create Customized Tables function, https://data.bls.gov/oes/#/home
LPNs, https://www.bls.gov/oes/current/oes292061.htm
CNAs, https://www.bls.gov/oes/current/oes311131.htm

CMS's continued use of hospital wages to calculate SNF Part A payment rates results in significant overpayments to SNFs.

Although the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. 106-554, authorizes CMS to establish a SNF-specific wage index, CMS describes the task as "unfeasible:"

> [A]uditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors (MACs), potentially far in excess of those required under the IPPS, given that there are nearly five times as many SNFs as there are inpatient hospitals.

89 Fed. Reg., 23431. As we have argued before, CMS's concerns are not persuasive. Requiring facilities to complete cost reporting worksheets should not be viewed as burdensome; it is essential to understanding how facilities spend their reimbursement. **Moreover, facilities are already required to complete cost reports.** The missing action is meaningful auditing of these cost reports.

The National Consumer Voice for Quality Long Term Care reported in its 2023 report *Where Do the Billions of Dollars Go? A Look at Nursing Home Related Party Transactions*, that there is little evidence that CMS seriously audits Medicare cost reports, when so many cost reports have blank pages or missing information and contain glaring errors. The result of the lack of federal oversight is that skilled nursing facilities, with impunity, divert billions of dollars from resident care to related party transactions. *See also* letter of 18 state Attorneys General supporting greater accountability in disclosure of ownership information and litigation filed by the New York State Attorney General against three nursing facilities (*The Villages of Orleans Health and Rehabilitation Center*, petition and Attorney General's Press Release; *Fulton Commons*, petition, Memorandum of Law in Support of the Verified Petition, and Attorney General's press release; and Cold Spring Hills, petition, Memorandum of Law in Support of Verified Petition, and Attorney General's press release.

The Center and LTCCC urge CMS to conduct audits of Medicare cost reports, as Congress authorized nearly 25 years ago, for two important purposes: (1) to begin the process of developing a SNF-specific wage index in order to avoid the overpayments that result from using hospital wages; and (2) to make sure that skilled nursing facilities stop diverting Medicare reimbursement from resident care to related parties and inflated profits.

At the very least, CMS must regularly run data integrity checks to identify cost reports with outlying or missing data for review and implement a spot audit process to evaluate a specified percentage of cost reports each year.

Require the submission of audited cost reports

In addition, CMS should propose regulations to require SNFs to submit audited cost reports (reports that have been audited by a certified auditing agency) to CMS annually, instead of completing and submitting cost report *forms*, as they do now. Facilities already have audited cost reports that they regularly use with investors and owners. For small facilities whose revenues do not exceed specified small amounts, the regulations could create exceptions to audited cost report requirements.

Rebasing and revising the SNF Market Basket, 89 Fed. Reg., 23436

The need for both auditing cost reports and requiring SNFs to submit audited cost reports is especially critical this year as CMS plans to rebase and revise the SNF market basket, using cost report data from 2022. CMS cannot simply assume that cost report data are accurate. There are too many indications of flawed and fraudulent data in many categories of cost reports, including related party data.

With respect to liability insurance: The Office of the Assistant Secretary for Planning and Evaluation issued *The Nursing Home Liability Insurance Market: A Case Study of Florida* (May 31, 2006), that relied on information from the National Conference of State Legislatures Health Policy Tracking Service. CMS should be looking for credible sources of information about SNF liability insurance, instead of using the CMS Hospital Professional Liability Insurance Index. 89 Fed. Reg., 23444. Hospital data are not relevant to nursing facilities.

Consolidated Billing, 89 Fed. Reg., 23435

Section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999) authorizes the exclusion of individual high-cost, low probability services within several broad categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that are otherwise subject to consolidated billing. We appreciate CMS's explicit solicitation this year of HCPCS codes in five categories (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices, and blood clotting factors). 89 Fed. Reg. 23436. We will continue to try to identify HCPCS codes.

SNF Quality Reporting Program, 89 Fed. Reg., 23461

Quality measures currently used in SNF QRP include nine MDS-based measures. 89 Fed. Reg. 23462, Table 28. We continue to oppose the use of minimum data set (MDS) (assessment-based) quality measures. MDS-based measures are often inflated by SNFs to give themselves higher ratings in the five-star quality rating system and to claim they have "five stars" in "quality."

CMS proposes four new items. 89 Fed. Reg. 23462. We agree that the Social Determinants of Health are critical for determining health outcomes. However, we do not understand how CMS plans to collect four new items related to living situation, food, and utilities as part of the resident assessment process. These items are relevant to individuals living in the community, but are not relevant to residents of institutions. MDS does not ask these questions.

SNF Value-Based Purchasing Program (SNF VBP), 89 Fed. Reg., 23470

The SNF VBP awards incentive payments to facilities, with the purpose and intention of encouraging improvements in care. Since the essentially for-profit nursing home industry strongly responds to financial incentives, it is critical that SNF VBP's incentive payments be appropriate.

We support CMS's proposed policy for selecting, retaining, and removing measures, 89 Fed. Reg., 23741-23472, although we continue to oppose any measures based on self-reported MDS data. We continue to oppose the Falls with Major Injury (Long-Stay) Measure because of its inaccuracy.

We believe that the scoring methodology, 89 Fed. Reg., 23474-23475, is too generous to facilities, giving quality bonuses to facilities that report data for (a minimum of) just four of eight measures. CMS should increase data requirements to at least six of the eight measures so that SNF VBP is actually addressing quality in multiple areas.

Improving health equity is critical. CMS should require all facilities to submit data on health equity in order to be eligible for SNF VBP incentive payments; in other words, health equity should be a mandatory measure for all facilities and any facility not meeting the measure's criteria should be denied any SNF VBP incentive payment.

Thank you for the opportunity to submit comments.

Sincerely,

Toby S. Edelman
Senior Policy Attorney
tedelman@MedicareAdvocacy.org
(202) 293-5760

Richard Mollot
Executive Director
Long Term Care Community Coalition